STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010886	A. BUILDING: _____ B. WING _____	C 01/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF MUNCIE	1601 N MORRISON RD MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00140649. Complaint IN00140649 - Unsubstantiated due to lack of evidence. Survey date: January 2, 2014 Facility number: 010886 Provider number: 010886 AIM number: N/A Surveyor: Betty Retherford RN Census bed type: Residential: 76 Total: 76 Census payor type: Other: 76 Total: 76 Sample: 3 Elmcroft of Muncie was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00140649. Quality review completed by Debora Barth, RN.	R 000		